Suspected Munchausen's Syndrome and Civil Commitment

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Munchausen's syndrome was named in 1951 by Asher[1] for the fictional, peripatetic purveyor of tall tales, Baron von Munchausen. This syndrome was classified in DSM-IV as factitious disorder with physical symptoms (DSM-IV 300.19). Diagnostic criteria include the intentional production or feigning of physical but not psychological symptoms. The motivation for the behavior is to assume the sick role, and external incentives for the behavior, such as economic gain, avoiding legal responsibility, or even malingering, are absent.[2]

Patients with Munchausen's syndrome utilize many different physicians and hospitals, often traveling from city to city, state to state, and even to foreign countries. The attainment of hospitalization often becomes the sole focus of such patients' lives. Individuals with this syndrome are frequently young adults who have work experience in a health care field (nurse, lab technician, ward clerk, etc.). There is some disagreement in the literature over the gender distribution of Munchausen's syndrome, with Eisendrath[3] stating that female patients equal or exceed the number of males and Sussman[4] and Nadelson[5] stating that males predominate.

Treatment and prognosis of Munchausen cases vary with the patient's need to assume the sick role. Patient resistance to the diagnosis is high, and these patients are often reluctant to engage in psychiatric treatment even when their behaviors are life-threatening. Situations can arise that lead to many ethical dilemmas.[6] Among these dilemmas is the possible need to involuntarily hospitalize some individuals with the disorder.

Most states allow emergency commitments for short-term hospitalization until a court hearing is held. Within days to weeks, a formal hearing is conducted to decide commitment for hospital-based or outpatient psychiatric care.[7] The standards of commitment in most or all states include, as a result of being mentally ill: danger to others, danger to self, or inability to care for self (grave disability). The criteria for being dangerous to self addresses suicidality or severely self-destructive behavior.[8] Other requirements often include the immediacy of the harm and the direct evidence of the threat or attempt. Wexler[9] argues that danger to self does not need to be restricted to suicide but can be broadened in interpretation to encompass other physical harm. What about individuals who knowingly hurt themselves for unconscious reasons or for secondary gain? Such is often seen in individuals with factitious disorder.

It appears that the major diagnoses of candidates for civil commitment are schizophrenia, mania, depression, or other psychoses.[10] However, Schlesinger *et al.*[11] conclude that, depending on the local statutes, one may be justified in using an emergency psychiatric commitment to protect an individual with Munchausen's syndrome from imminent self-harm. Cleveland *et al.*[12] concluded that persons whom psychiatrists consider highly in need of treatment may be viewed as meeting the dangerousness criteria for commitment if these persons refuse to voluntarily admit themselves. We believe this criterion could apply to the following case.

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Case Report

Ms. P was a 42-year-old, divorced, Caucasian female who worked as a nurses' aide. She was admitted for evaluation of increasingly frequent firing of her automatic internal cardioverter defibrillator (AICD). This device had been implanted approximately eight months previously for treatment of her congenital long QT syndrome. This defect in the heart's conduction system had resulted in frequent episodes of ventricular tachycardia, leading to cardiac arrest. A medical workup revealed hypokalemia ($K = 2.0$ on admission) to be the most likely cause of the frequent AICD firing; however, no organic etiology was initially apparent for the hypokalemia. A review of medical records revealed a history of suspected diuretic abuse resulting in documented instances of hypokalemia. Laboratory findings showed evidence of diuretics in Ms. P's system. Despite this finding, Ms. P adamantly denied past or present use of diuretics. She became hostile and demanded to leave, against medical advice, at the implication of self-induced hypokalemia and its sequelae. Given this problematic situations, Ms. P's medical team felt that she would be at acute cardiac risk if she were discharged while using diuretics against medical advice. Therefore, a psychiatrist was consulted to assist with the diagnosis and disposition.

The psychiatric consultant's review of Ms. P's past medical records produced these additional diagnoses: (1) ulcerative colitis, diagnosed at age 14 and leading to colectomy at age 18; (2) Crohn's disease leading to ileostomy; (3) renal insufficiency of unknown etiology; (4) pancreatitis; (5) anemia secondary to renal failure; (6) aspiration pneumonia secondary to methadone overdose; (7) multiple abdominal complaints including pain, abscesses, and hemorrhage of unknown etiology; and (8) endometriosis. By self-report, Ms. P had undergone in excess of 20 surgical procedures, which was consistent with the scars observed on physical examination.

Ms. P's psychiatric history was significant for prescription narcotics and benzodiazepine dependence, prescription forgery, and alcohol abuse. She also had a history of recurrent depressive episodes and a diagnosis of personality disorder NOS, with histrionic and borderline features. Records indicate one instance of wrist-slashing at age 33. Ms. P reported having been a victim of sexual abuse by a paternal uncle.

Ms. P's past history and current clinical presentation were thought to be consistent with a diagnosis of a factitious disorder with physical symptoms (DSM-IV 300.19). Although Ms. P was not considered to be suicidal, her behavior (diuretic abuse leading to hypokalemia, in turn leading to high risk of acute cardiac arrest) was imminently life-threatening and directly related to her psychiatric diagnosis. On this basis, it was determined that she met the criteria for emergency civil commitment under the danger to self standard. Therefore, she was transferred against her will to a county psychiatric hospital for further evaluation and eventual treatment.

Discussion

Emergency commitment criteria are, in most states, limited to dangerousness to self or others. Rarely is dangerousness to others a factor for Munchausen's patients, except in the case of Munchausen's by proxy.[13] In this case, criminal charges, rather than civil commitment, are the likely fate of the patient. Dangerousness to one's self usually involves suicidal action or intent. Suicidality is conspicuously absent in Munchausen's syndrome. However, the behaviors utilized to feign symptoms and achieve the sick role may at times be life-threatening.[14]

Houck[15] stated that individuals who suffer from factitious disorder have self-injurious behaviors, which could even culminate in death, caused by the desire to become a patient rather than a desire to commit suicide. He stated that although this type of behavior could be grounds in some jurisdictions for dismissal of a civil commitment based on danger to self, in some cases the potential for self-destruction is so compelling that it could warrant involuntary commitment. There are only a few cases documented in the literature in which individuals were referred for civil commitment based on complications secondary to factitious disorder.[15–17]

Different ways of dealing with the difficulty of treating a Munchausen's patient have been proposed. McFarland[18] proposed that consideration should be given to assigning a guardian to take care of the Munchausen patient. The guardian would then be able to provide the temporary legal stability that is necessary to gain control of potentially dangerous medical situations seen in some Munchausen patients. However, cases have been described in which individuals with factitious disorders have died secondary to the mental illness from which they suffer.[14, 19] The key issues are the degree of lethality of these behaviors

and the immediacy of the threat to life. We contend that in these situations, involuntary civil commitment of a Munchausen patient is not only therapeutic but may be necessary to save a life. This was felt to be the situation in the case of Ms. P.

Although treating an individual who suffers from factitious disorder is likely to be difficult, there are at least a few documented cases of successful treatment when under commitment.[16, 17] Obviously, clinicians will not utilize this approach lightly. They must have sufficient evidence from current and past hospitalization reports to support the diagnosis of Munchausen's syndrome. Moreover, the benefit of involuntary commitment, in terms of ensured patient safety, must outweigh the suspension of a patient's civil liberties. Again, this appeared to be the case for the person presented in this paper. Therefore, the risk-benefit ratio of involuntary commitment must be carefully weighed on a case-by-case basis.

Conclusion

Individuals who suffer from Munchausen's syndrome sometimes engage in life-threatening behaviors. It is important to consider the means by which these individuals could be adequately and successfully treated. Involuntary commitment may be the only saving modality in severe cases. Because of the dearth of literature about this concept, we recommend that further research be done on the outcome of civil commitment for individuals with factitious disorders. The ethical dilemmas associated with civil commitment of these patients also require further comment.

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